RHODE ISLAND DEPARTMENT OF ENVIRONMENTAL MANAGEMENT
PHYSICIAN'S OPINION LETTER -- MEDICAL RESPIRATOR CERTIFICATION

(This top section is to be completed by the employee/applicant who later signs below)

Employee Name: _____

Date: _____

Division: _____

Site Location: _____

_____

(This middle section is to be completed by a physician or health care professional)

I HAVE EXAMINED THE ABOVE NAMED APPLICANT/EMPLOYEE AND FIND AS FOLLOWS:

_____The examination indicated no significant medical impairment. The employee/applicant can be assigned an

_____The examination indicates that a medical impairment currently exists that limits respirator use as follows:
_____ The employee/applicant cannot wear a negative air purifying respiration
_____ The employee/applicant can wear a negative air purifying respirator
only under these conditions:

_____

_____

_____ The applicant/employee should be reevaluated in ( ) year(s).

Note: If not otherwise stipulated, as stated in RI DEM's policy, the employee/applicant will be reevaluated every 5 years.

I HAVE INFORMED THE APPLICANT/EMPLOYEE OF PERTINENT RESULTS AND FINDING OF THIS EXAMINATION AND A COPY OF THIS OPINION LETTER HAS BEEN ISSUED TO HIM/HER.

_____
Physician's/Health Care Professional Signature

Address: _____ Telephone Number: _____
_____
_____

_____

_____
Employee/Applicant Signature – certifying receipt of a copy of this letter

_____
RIDEM – Office of Human Resources